STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345172	A. BUILDING ______ B. WING ______	C 12/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRIAD CENTER	**707 NORTH ELM STREET** **HIGH POINT, NC 27262**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, the facility failed to obtain a physician ' s order prior to applying a medication on 1 of 3 residents (resident # 3). Findings Included: Resident #3 was admitted on 7/21/13 with a readmission on 9/11/15. Diagnoses included anemia, heart failure, urinary tract infections, diabetes, stroke, depression and anxiety. A record review of the Minimum Data Set (MDS) quarterly assessment dated 10/1/15 revealed Resident #3 is cognitively intact. Resident #3 required extensive assist with one-person assist with all activities of daily living (ADL ' s), two-person assist with transfers and is a set up only with meals. The resident is always incontinent of bladder and bowel. A record review of the care plans updated on 10/2/15 revealed the following care plans and interventions: assistance with ADL ' s: approaches included to assist with all ADL care, keep call light within reach, monitor for pain or discomfort. At risk for alteration in comfort related to pain: approaches included turn and reposition, evaluate pain, medicate as ordered for pain and monitor for effectiveness. At risk for skin breakdown: approaches included monitor	F 281	1. Resident #3 remains in the facility and new orders were received for treatment to the scrotal and groin area on December 1, 2015. 2. The LPN Nurse #1 working at the time of the survey on 12-1-15 was re-educated on 12-3-2015 about the need to obtain an order prior to treating a resident and to call the MD/NP to obtain the order if a standing order is not in place for any treatments needed. An audit was conducted and residents currently being treated for any type of scrotal/groin redness or rash have a treatment in place. 3. Licensed nurses were in-serviced beginning on December 3,2015 to ensure that all nurses complete the in-service will cover the new additional standing orders from the Medical Director Dr. Long fro Skin Care and Moisture Associated Skin Damage; as well as the proper procedure for completing the required documentation and notifying the provider and obtaining treatment orders for all new skin areas. 4. The Wound Specialist will conduct random weekly checks to ensure that areas being treated have an accurate order and that all new areas are	12/30/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/18/2015

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 281	Continued From page 1 skin for signs and symptoms of skin breakdown, observe skin condition with ADL care and report abnormalities, weekly skin assessment by licensed nurse. On 12/1/15 at 12:49 am, an observation of incontinent care was done with NA #1. The NA informed the resident that she was going to check to see if he needed to be changed. The NA washed her hands, applied gloves and unfastened his briefs. The NA reported that he was dry and did not need to be changed. However, she noticed that his groin area and scrotum was red. The NA covered the resident and reported her findings to Nurse #1. Nurse #1 entered the room, washed her hands, applied gloves and applied Z Guard (which is zinc oxide) to the resident ' s left and right groin area and scrotum. The resident cried out that it was burning. The nurse replied she would have the Nurse Practioner (NP) look at it. She continued to apply the Z Guard and then fastened his briefs. The resident continued to complain that it was burning. On 12/1/15 at 12:50 pm, an interview with NA #1 revealed that this was the first time she had seen the redness to his groin and scrotum. On 12/1/15 at 1:00 pm, an interview with Nurse #1 revealed she usually does not have this resident and had never seen the excoriated areas to his groin and scrotum. The nurse reported the resident gets the Z guard applied twice per day and as needed. A record review of the physician ' s orders was completed on 12/1/15 at 1:05 pm. There was no order to apply Z guard to the resident ' s groin or	F 281	documented correctly. The audits will will continue with random weekly checks for the next 12 weeks. Findings will be presented to the PI Committee monthly for three months. The Director of Nursing will be responsible for the compliance of this practice.	

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F 281	Continued From page 2 scrotum twice per day or as needed. On 12/1/15 at 3:00 pm, an interview with Nurse #2 revealed that Z guard (zinc oxide) is not a standing order and that it has to be a verbal order from the physician. At this time, Nurse #2 provided a list of physicians ' standing orders. Zinc oxide was not listed as a standing order. On 12/2/15 at 2:48 pm, an interview was conducted with Nurse #1 via telephone. Nurse #1 reported that she forgot to put the order for the Z guard in the computer before she left for the day on 12/1/15. She reported she did not speak with the Physician or the NP. She stated that it was a standing order and it is okay to go ahead and use it without a verbal order from the physician. She also reported that she did not tell the NP about the excoriated area on 12/1/15 because the NP had already left for the day. On 12/2/15 at 3:15 pm, an interview with Director of Nursing (DON) was conducted. The DON reported that her expectation was for the nurse to call the NP or the Physician to notify them of the new excoriated area and obtain an order to treat it	F 281		